"THE UNSUCCESSFUL AGED"

A STUDY OF PROBLEMS AROUND HOSPITAL DISCHARGE PLANNING FOR THIRTY-TWO SENILE PATIENTS ADMITTED TO RECEIVING HOSPITAL, DETROIT, MICHIGAN, JANUARY TO JULY, 1953

A THESIS

SUBMITTED TO THE FACULTY OF ATLANTA UNIVERSITY

IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR

THE DEGREE OF MASTER OF SOCIAL WORK

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SCHOOL OF SOCIAL WORK

ATLANTA, GEORGIA

JUNE 1954

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CHAPTER I

INTRODUCTION

Significance of the Study

In reading Plato's The Republic written about 370 B.C., one finds Cephalus, an aged man, requesting Socrates to visit him so that he may have the opportunity of conversing with him. Socrates replies:

> There is nothing which for my part I like better, Cephalus, than conversing with aged men; for I regard them as travelers who have gone a journey which I too may have to go, and of whom I ought to inquire whether the way is smooth and easy or rugged and difficult. And this is a question which I should like to ask of you, who have arrived at that time which the poets call the 'threshold of old age': Is life harder toward the end, or what report do you give of it?

Cephalus says in answer that many of the aged assemble together and discuss their grievances. Life is different for many, and they attribute their numerous difficulties to their age. Cephalus does not agree with them. He adds:

> The truth is, Socrates, that these regrets, and also the complaints about relations, are to be attributed to the same cause, which is not old age, but men's characters and tempers; for he who is of a calm and happy nature will hardly feel the pressure of age, but to him who is of an opposite disposition youth and age are equally a burden.[1]

Indeed, the problem of the care of the aged is not new--it is as old as time itself.

However, within the more recent decades there has been a more rapid growth of interest in the years of later life. Why? In the first place

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[1]Sahra Rapp, "Boarding Care for the Aged Sick," Personalized Care for the Aged Client. Reprinted from The Family, July, 1946, p. 12.

the population of the aged is growing very rapidly. In 1900, for example, there were only a little over three million persons in this country over sixty-five years of age. Today there are more than thirteen million persons representing almost nine per cent of the population over sixty-five years of age.[1]

With a population which is growing older there has been an increase in the number of mental disorders in later life, and this is marked after the age of sixty-five years. The National Institute of Mental Health, in making a statistical analysis of first admissions to United States hospitals for the mentally ill, found that almost one-third of the first admissions occurred in individuals sixty years of age and over.

The City of Detroit Receiving Hospital has found this evidenced as the heavy influx of senile patients to its psychiatric wards continues.

Related to the impetus of admissions is the difficult problem of planning for the senile patient. Though the Social Service Department of the City of Detroit Receiving Hospital has placed many, the obstacles to placement and the patients' adjustments are multifarious.

This study is an evaluation of the discharge plans made for the senile patient in the light of social, medical, and psychological factors.

It is hoped that the study is of value to psychiatrists, physicians, social workers, nurses, institutional personnel, and others specializing in health, welfare, and adjustment problems of the aged.

Purpose of the Study

The purposes of the study were: (1) to discuss the medical and psychological aspects of senility; (2) to discuss general aspects of adjustment

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[1]Jeanne G. Gilbert, Understanding Old Age (New York: 1952), p. 3.

in old age; (3) to present and describe problems presented by the senile patient; (4) to indicate the activities of the medical social caseworker in planning for the senile patient; (5) to evaluate the plans in consideration of the patient's needs and his subsequent adjustment; and (6) to make the findings available to the Departments of Social Service and Psychiatry for further study and reference.

Method of Procedure

As a means of obtaining more knowledge and fuller insight into the problem of placing senile patients and their subsequent adjustment, all available literature pertaining to the subject was read and studied.

The chief source of data was the patient's medical record. It provided knowledge of the patient's admitting diagnosis, reasons for emergency hospitalization, medical history, Social Service note, final medical and psychiatric diagnosis, and final disposition. The Social Service face sheet was used to obtain identifying data.

Interviews with personnel of agencies to which the patient was referred yielded data pertaining to the patient's adjustment and present status as such. Contacts with the patient's family were for the purpose of obtaining further knowledge of the reason for the patient's need for immediate hospitalization and the family's attitude toward arrangements for post hospital care.

Scope and Limitations

All data were collected in Wayne County, Detroit, Michigan. The study included thirty-two senile patients admitted to the psychiatric wards of City of Detroit Receiving Hospital from January 1, 1953 to July 1, 1953, and only those patients with whom the Social Service Department had contact.

In selecting the cases the writer took the total case load of the year

1953, separated those patients who were admitted between January and July, and obtained a total of 128 cases. Every fourth case, beginning with the fourth case, was chosen to arrive at a sample of thirty-two patients. This sample included female patients, white and non-white, who were sixty years of age and over.

CHAPTER II

SETTING OF THE STUDY

Description of the Hospital

The City of Detroit Receiving Hospital, a municipal emergency hospital, was authorized in 1913 by a city charter and was opened in 1915 under the auspices of the Department of Public Welfare. On January 1, 1950, the hospital became a part of the Board of Health. In 1953, the new Farwell Building was annexed to Receiving Hospital, thus enlarging and expanding the medical services and facilities.

The hospital provides for 722 beds, 188 of which are allocated for services for mental patients and police prisoners. The remainder consists of medical and surgical beds.

Initial treatment is given in the emergency ward to ambulatory patients and general first-aid cases, without regard for the patients' legal settlement or financial status.

All patients are billed for services rendered. After admission, a patient who is hospitalized over seventy-two hours is referred to the Wayne County Department of Social Welfare. If the "application is approved, arrangements for payments or decision as to free care are made by the county."[1] Patients with a minimum income are required to pay according to a budget employed by hospital investigators.

The City Physicians' Division provides free out-patient clinic care to patients found eligible by the Hospital Investigation Bureau. No referral is needed for acceptance; however, most patients are referred from within

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[1]Manual of Policy and Procedure, City of Detroit, Department of Public Welfare, Bureau of Social Service, Item 207.

the hospital and from other agencies.

Psychiatric wards are maintained for temporary custodial care for those patients under mental observation. This will be discussed in greater detail later in the chapter.

The Social Service Department

The Social Service Department was established in 1916,

> . . . as a service to the patient, the physician, the hospital administration, and to the community. It is designed to help meet the problem of the patient whose medical need may be aggravated by social factors and who, therefore, may require social treatment based on his medical condition and care.[1]

The increased specialization of the Social Service Department was a concomitant of the specialization in the field of Medical Social Case Work during the recent years.

> During the first ten years in operation, the social workers were assigned to the hospital-at-large, with no apparent attempt to employ the services of certain workers on specific wards, services, or functions.[2]

Presently, however, the administration has defined all positions within the department and each worker has an individual assignment and specific function. The staff of the Social Service Department consists of eighteen members including the Director, the Assistant Director, social caseworkers and clerical staff.

The Director is responsible for only this department and is directly responsible to the medical superintendent and business manager of the hospital. The other workers engage in casework services to the patients as a primary function of the department. The activities in which the social ser-

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[1] Ibid., Item 213.

[2] Carolyn J. Seefeldt, "An Analysis of the Receiving Hospital Social Service Department, Detroit, Michigan" (Unpublished Master's thesis, Institute of Social Work, University of Michigan, 1949), p. 5.

vice department engages are:

1. Practice of social casework.
2. Participation in program planning and policy formulation within the medical institution.
3. Participation in the development of social and health programs in the community.
4. Participation in the educational program for professional personnel.
5. Social research.[1]

One last function of the Social Service Department is to conduct a student training program leading to a Masters' Degree. The department provides this placement for students of the Atlanta University School of Social Work, the University of Michigan Institute of Social Work, and the Wayne University School of Social Work.

The Department of Psychiatry

Receiving Hospital has four mental observation wards with a total capacity of 188 beds. Two of the wards are assigned for temporary custodial care of male patients under observation, alcoholics, police prisoners, and medical and surgical cases which warrant this service. The other two wards are for female patients and are used as are the male wards.

The procedure for admittance to the psychiatric wards is that a city physician order the hospital to admit, or order the police department to bring in for admission, a patient for an observation period of five days. Patients may also be admitted through the psychiatric out-patient department if the psychiatric evaluation and findings of the psychiatrist and the social worker are indicative of such.

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[1]The American Association of Medical Social Workers, "A Statement of Standards to be Met by Medical Social Service Departments in Hospitals and Clinics" (Washington, 1949), p. 3.

There are ten psychiatrists on the staff, who are assigned to the female wards, male wards, admitting room, and to the psychiatric out-patient clinic in proportion to the quantity of service needed in each division. One psychologist is also a member of this staff.

The chief function of the mental observation service within the department is to screen patients on the wards and to determine by means of interviews, social histories, and tests, whether the patient is to be recommended for further hospitalization, referred to another service, or discharged.

CHAPTER III

CHARACTERISTICS OF PATIENTS STUDIED

In defining "senium," or "old age," the first inclination is to give a temporal definition--old age is a period after a certain birthday, perhaps the sixtieth or sixty-fifth. This, of course, depends upon the point of view. "To the small child the adolescent of fifteen is old; to the youth of twenty-five the man of forty-five is old; to the man of seventy-five only the nonagenarian is really old."[1] Stieglitz suggests the division of the life span into four overlapping periods. They are as follows: evolutional phase, ages zero to twenty-three; maturation, ages eighteen to forty-five; senescence, ages thirty-seven to sixty-nine; and involutional, ages sixty to one hundred.[2]

However, individual differences in the rate of growing old show the fallaciousness in any definition of old age. One person may be "old" emotionally, physically, and mentally at forty-five and another may be "young" at seventy-five. In this chapter, the writer attempted to provide a more enriched understanding of the process of aging by tracing some of the changes associated with it through the entire period of later maturity, from sixty on. The prevalence of many social and physical characteristics are presented here.

An analysis of Census Data by Cavan, Burgess, Havighurst, and Goldhamer was done in 1949 which covered all old persons sixty years of age and over in the United States. Their findings indicated that increased age was associated with some of the following trends: a higher percentage of widows;

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[1] Jeanne G. Gilbert, op. cit., p. 3.

[2] Edward J. Stieglitz (ed.), Geriatric Medicine (Philadelphia, 1943), p. 9.

a higher percentage living in dependent family relationships--in institutions, with sons and daughters, or with relatives; greater dependence on pensions, Old Age Assistance, and with children for support; an increase in physical handicaps, illness, nervousness, a decrease in feeling of satisfaction with health; and a lower median score, indicating poorer adjustment.[1]

This study group consisted of thirty-two senile patients, white and non-white, sixty years of age and over. These patients are ones who were admitted to Receiving Hospital between January 1953 and July 1953. Only female patients were included in the group.

Age, Race, and Nationality

The number of persons in each succeeding five-year period from age sixty on decreases slowly. Table 1 shows the number of patients for each five-year period in addition to race and nationality.

TABLE 1

SENILE PATIENTS ADMITTED TO RECEIVING HOSPITAL
BY AGE, RACE, AND NATIONALITY,
JANUARY-JULY, 1953

Age	Total	Patients Admitted			
		White		Non-White	
		Native-Born	Foreign-Born	Native-Born	Foreign-Born
Total	32	18	10	4	-
60 - 64	9	3	5	1	-
65 - 69	6	3	2	1	-
70 - 74	7	4	2	1	-
75 - 79	3	2	-	1	-
80 - 84	3	3	-	-	-
85 - 89	2	2	-	-	-
90 - 94	2	1	1	-	-

[1] Ruth Cavan and Others. Personal Adjustment in Old Age (Chicago, 1949), p. 40.

The median age of the study group was seventy-two. The sample had more patients in the sixties and fewer in the seventies and early eighties. It is significant to note that the number of foreign-born and native-born in the sixties was almost the same. There was also a marked difference between the number of white and non-white, the latter comprising approximately one-eighth, four, of the total number. No non-white foreign-born senile patients were admitted. This group was composed of all Negro patients.

Marital Status and Family Constellation

The normal intimate group of the adult is the family. If this can be kept in mind then it is not too difficult to see that the lack of family life or nonexistence of a family might have detrimental effects on a person, young or old, but especially more applicable with the old person. Such was seen in the case of Mrs. H, seventy-one, who was admitted to the hospital two weeks following the death of her husband. She was described as being in an agitated depressive state and could not be cared for at home. Such an adult situation reaction often occurred when the aged person was left alone by deaths of closely-related family members. Table 2 shows the number of the single, married, separated, widowed, and divorced for each age period.

The figures given in the following table show that over two-thirds, twenty-three, of the female patients were widows. With each passing period the number gradually decreases as does the number of patients falling in the five-year periods decrease. Separations and divorces were not a typical problem of old age and it seems evident that remarriages in the older age period were not common. The high death rate among the old usually strikes but one member of the marriage, leaving a widow or widower.[1] When the number

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[1] Ibid., p. 42.

of widows for each age period is considered separately, the detachment and implied loneliness of these patients was vividly apparent.

TABLE 2

DISTRIBUTION OF THE SENILE PATIENTS SIXTY YEARS OF AGE AND OVER, BY MARITAL STATUS AND AGE AT RECEIVING HOSPITAL, JANUARY-JULY, 1953

Age	Total	Single	Married		Widowed	Divorced
			Living with Spouse	Not Living with Spouse		
Total	32	3	5	1	23	-
60 - 64	9	-	3	-	6	-
65 - 69	6	-	2	-	4	-
70 - 74	7	2	-	-	5	-
75 - 79	3	1	-	-	2	-
80 - 84	3	-	-	-	3	-
85 - 89	2	-	-	-	2	-
90 - 94	2	-	-	1	1	-

The family constellation aspect is closely related to marital conditions. The reasoning supporting this is the previously-mentioned one--the normal intimate group of the adult is the family.

It was found that approximately one-third, twelve, of the study group had no children. This number included the number of patients who were single and the number of patients whose children were deceased, three and one respectively. Approximately one-third, twelve, of the patients had only one child. Three of the patients had three children each, one patient had four children, one patient had six children, another had eight, and the family constellation of three of the patients was unknown.

The children of the patients were adult persons with families of their own, with the exception of one case in which the adult child was single. As was anticipated, in many cases the children resided in places other than Detroit and the State of Michigan. This seems to be an indication that the

unity and intensity of family life has changed and diminished with increased age.

Financial Status and Previous Living Arrangements

The question of financial support has received more attention in recent years than has any other aspect of later maturity. The fact that the elderly person is not employable after sixty-five may mean that the person is unable to meet his financial needs. Mrs. Q, a sixty-six-year-old woman who was employed by a family and received her meals in return for her work, exemplifies the above. It was evidenced that not only are the persons unable to meet their financial needs but that the over-all standard of living of the old is lowered. For a person who has not experienced such previously, the change to which the person must adjust may be too difficult and he may be unable to do so satisfactorily.

Of equal significance and as closely related to marital condition and financial status were the living arrangements of aged people. The latter is not entirely dependent upon the former, however.

The chief means of support and the living arrangements, prior to hospitalization, of the study group are shown in Table 3.

Investments, annuities, and other savings (representing bank accounts, trust funds, and insurances) gave chief support to approximately one-third, twelve, of the study group. The proportion receiving full support from Old Age Assistance was about the same as that of the already-mentioned source of income. The small number of the aged patients completely dependent upon their children, five, reflects the change in thinking and practice from care of the parents by the children to independent provision or dependence upon public funds. The actual shift to dependence upon some agency comes in the early seventies. Four of the patients' sources of income were from present

earnings. The occupations were listed as seamtress, laundress, elevator operator, and tearoom fortune teller.

TABLE 3

DISTRIBUTION OF CHIEF MEANS OF SUPPORT AND LIVING ARRANGEMENTS OF SENILE PATIENTS PRIOR TO ADMISSION TO RECEIVING HOSPITAL, JANUARY-JULY 1953

Age	Total	Means of Support					Total	Living Arrangements				
		Employment	Investments Annuities Other Savings	Old Age Assistance	Children	Other Relatives		Own Home	With Children	Other Relatives	Room	Institution
Total	32	4	12	11	5	-	32	6	8	2	12	4
60 - 64	9	-	6	2	1	-	8	2	2	1	2	1
65 - 69	6	2	2	1	1	-	6	1	1	-	3	1
70 - 74	7	-	2	5	-	-	6	2	2	-	-	2
75 - 79	3	-	-	2	1	-	4	-	-	-	2	2
80 - 84	3	1	1	-	1	-	3	-	-	-	3	-
85 - 89	2	1	-	-	1	-	3	1	-	1	1	-
90 - 94	2	-	1	1	-	-	2	-	1	-	1	-

Many of the patients lived in the homes of their children as Table 3 shows. This group, comprising almost one-fourth, eight, of the sample was composed of widows. "When widowhood is combined with a move into the home of a son or daughter, habits of many years duration are destroyed."[1] Mrs. R was a sixty-three-year-old widow who previously lived in her home alone but who kept roomers. After numerous hospitalizations, the home had to be sold to meet medical expenses and Mrs. R was then forced to move into her niece's apartment. Not only were her "habits of many years destroyed" but she was completely maladjusted in the new environment. The idealized philosophy of

[1] Ibid., p. 44.

family life is indicative that the child would institute a new strong, tender relationship with the aged person. Realistically, however, this does not always happen. Therefore, the integration of the aged person into the family circle may be unsuccessful.

Many of these patients, eight, had previously lived alone (in hotels, rooming houses, and apartments). Three-fourths of this group were patients with families and the remaining one-fourth were unattached. This may be a direct cause and/or indication of the heretofore-mentioned shift in the trend toward independent provision. The number of patients who lived alone in their own homes, institutions (convalescent homes and outlying hospitals), and with other relatives decreases respectively.

Medical Diagnoses

Aging is growth and concurrent with growth are certain physiological changes and degenerations.

> . . . Dr. William Welch, the famous dean of the Johns Hopkins University Medical School, pointed out some years ago that medical progress depends not only on the acquisition of new knowledge but also on the application of the knowledge we already have. This is surely true of the aged group. There is an attitude of defeatism on the part of many physicians toward old people, which thwarts all constructive efforts; confronted by a sick man or woman, they are apt to throw up their hands and exclaim, 'What's the use? We can't provide new hearts or new kidneys.'[1]

Until recently, it seems that the outlook for the senile patient was far too pessimistic. Now, however, it is more widely known and accepted that much can be done to improve the aged person.

A summary of some of the findings of the National Health Survey indicates some of the physical illnesses of old people:

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[1]Frederic Zeman, "Physical Illnesses and Mental Attitudes of Old People," Mental Hygiene in Old Age (New York Family Welfare Association of America), p. 39.

> The frequency of all types of illness among those over 65 is very high, about equal to that among children from 5 to 9 years of age. Moreover, illness in these later years is often prolonged; one estimate indicates that the average person 65 years of age and over will have about five weeks of disabling illness per year. Chronic illness and invalidism are common to the fact that death from degenerative diseases are preceded often by months of failing health, followed by illness that progresses toward a fatal termination. Diseases of the respiratory tract are frequent and digestive disorders are more frequent than at any other period except infancy . . . . The National Survey found that about 68 of every 1,000 persons surveyed among this age group were handicapped by some orthopedic impairment. The Survey also emphasized the increased frequency of blindness with advancing age.[1]

Some authorities in the field of Gerontology, such as Gilbert, Zeman, Cohn, Nascher, Bowman, and Fisher list fractures, arthritis, heart and circulatory disorders, cancers, pneumonia, hypertension, digestive disturbances, and arteriosclerosis as diseases of the aged. These are broken down into more extensive classifications.

Dr. Zeman states that most old people suffer from two or more diseases simultaneously. This is especially true of this study group as is shown in Table 4 and in the case of Mrs. C, a sixty-nine-year-old female whose admitting diagnoses were: senile, diabetes, arteriosclerosis, and nephritis. These multiple diseases are definitely related to adjustment, as shown in Mrs. C's case. She was placed in a convalescent home but was discharged because she was "unruly and caused too much trouble." She was noisy, refused to stay in bed, and demanded too much care. Her son mortgaged his home in order to meet the extra expenses of a private nurse.

The patients who were admitted to Receiving Hospital were first given an emergency examination at the time of admission to the hospital. If hospitalization was necessary, patients were then transferred to medical, surgical, or psychiatric wards where a more thorough and complete examination was given.

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[1]National Resources Planning Board, "Human Conservation, the Story of Our Wasted Resources" (Washington, 1943), pp. 92-93.

TABLE 4

MEDICAL DIAGNOSES OF SENILE PATIENTS ADMITTED TO RECEIVING HOSPITAL
BY CLASSIFICATION AND FREQUENCY, JANUARY-JULY, 1953

Number	Medical Diagnoses										
	Primary						Secondary		Preferential		
	Heart Disease	Hyper Cardio Vascular Disease	Arterio Sclerosis	Hypertension	Brain Disease	Cirrhosis	Cerebral Thrombosis	Cerebral Hemorrhage	Carcinoma	Diabetes Mellitis	Nephritis
1	...	...	...	...	...	...	...	...	...	...	...
2	X	...	...	...	...	...	...	...	...	X	...
3	...	...	...	...	X	...	...	...	...	...	...
4	...	...	...	...	...	...	...	...	...	...	...
5	...	...	X	...	...	...	...	...	X	...	...
6	...	...	...	X	...	...	...	...	...	...	...
7	...	...	...	...	X	...	...	...	...	...	...
8	...	...	...	...	...	...	...	...	...	...	...
9	X	...	...	X	...	...	...	X	X	...	...
10	...	...	...	...	X	...	...	...	...	...	...
11	X	...	...	X	...	...	...	...	...	...	...
12	...	...	...	...	...	...	...	...	...	...	...
13	...	...	X	...	...	...	...	...	...	...	...
14	...	...	...	...	...	...	...	...	...	...	...
15	...	...	...	...	...	...	...	...	...	...	...
16	...	...	X	...	...	...	...	...	...	...	...
17	...	...	...	...	X	...	...	...	...	...	...
18	...	X	...	...	...	...	X	...	...	...	...
19	...	...	X	...	...	...	...	...	X	...	...
20	...	...	...	...	...	X	...	...	...	...	...
21	...	X	...	...	...	...	...	...	...	...	...
22	...	...	...	...	...	...	...	...	X	...	...
23	...	...	...	...	...	...	...	...	...	X	...
24	...	...	...	...	...	...	...	...	...	...	...
25	...	...	X	...	...	...	...	...	...	...	...

TABLE 4--Continued

Number	Medical Diagnoses											
	Primary						Secondary		Preferential			
	Heart Disease	Hyper Cardio Vascular Disease	Arterio Sclerosis	Hypertension	Brain Disease	Cirrhosis	Cerebral Thrombosis	Cerebral Hemorrhage	Carcinoma	Diabetes Mellitis	Nephritis	
26	...	X	X	...	...	...	...	...	...	...	...	
27	X	...	X	...	...	...	...	...	...	...	...	
28	...	...	...	...	...	...	...	...	...	...	...	
29	...	...	...	...	...	...	...	...	...	...	...	
30	...	...	...	...	...	...	...	...	...	...	...	
31	X	...	...	...	...	...	X	...	...	...	...	
32	...	...	X	X	...	...	...	...	...	X	X	
Total	5	3	8	4	4	1	2	1	4	3	1	

Number	Modified						Uninfluenced							Total Number
	Diarrhea	Ulcer	Tumor	Pneumonia	Deaf	Blind	Malnutrition	Tuberculosis	Syphilis	Parkinson's Disease	Obesity	Dehydration	Addiction	
1	...	...	...	...	...	...	...	...	...	...	...	...	X	1
2	...	...	...	X	...	...	...	...	...	X	...	...	...	4
3	...	...	...	...	...	...	...	...	...	...	...	...	...	1
4	X	...	...	...	...	...	X	...	...	...	...	...	...	2
5	...	...	...	...	...	...	X	...	...	...	...	...	...	3
6	...	...	...	...	...	...	...	...	...	...	...	...	...	1
7	...	...	...	...	...	X	X	...	...	...	...	...	...	3
8	...	...	...	...	...	...	...	...	...	...	...	X	...	1
9	...	...	...	X	...	...	...	...	...	...	...	X	...	6
10	...	...	...	...	...	...	...	...	...	...	...	...	...	1
11	...	...	...	...	...	...	...	...	...	...	...	...	...	2
12	...	X	...	X	...	...	...	...	...	...	...	...	...	2
13	...	...	...	X	...	...	...	...	...	...	...	X	...	3

TABLE 4--Continued

Number	Medical Diagnoses													Total Number
	Modified						Uninfluenced							
	Diarrhea	Ulcer	Tumor	Pneumonia	Deaf	Blind	Malnutrition	Tuberculosis	Syphilis	Parkinson's Disease	Obesity	Dehydration	Addiction	
14	...	...	...	...	...	...	...	...	...	...	...	...	...	0
15	...	...	...	...	...	...	...	...	...	...	X	...	...	1
16	...	...	...	...	X	...	...	...	...	...	X	...	...	3
17	...	...	X	...	...	...	X	...	...	...	...	...	...	3
18	...	...	...	...	...	...	...	...	...	...	...	...	...	2
19	...	...	...	...	...	...	...	...	...	...	...	...	...	2
20	...	...	...	...	...	...	...	...	...	...	...	...	X	2
21	...	...	...	...	...	X	X	...	...	...	...	...	...	3
22	...	...	...	...	...	...	X	...	...	...	...	...	...	2
23	...	...	...	...	...	...	...	...	...	...	...	...	...	1
24	...	...	...	...	...	...	...	X	X	...	...	...	...	2
25	...	...	...	...	...	...	...	...	...	...	...	X	...	2
26	...	...	...	...	...	...	...	...	...	...	...	...	...	2
27	...	...	...	...	...	...	...	X	...	...	...	X	...	4
28	...	...	...	...	...	...	...	...	...	...	...	...	...	0
29	...	...	...	...	...	...	...	...	...	...	...	...	...	0
30	...	...	...	...	...	...	...	...	X	...	...	...	X	2
31	...	...	...	X	...	X	...	...	...	...	...	...	...	4
32	...	...	...	...	...	...	...	...	...	...	...	...	...	4
Total	1	1	1	5	1	3	7	2	1	1	2	5	3	69

In view of the prevalence of illnesses and handicaps suggested by the preceding quotations it is interesting to note that these facts were in definite relation to Table 4, the medical diagnoses of senile patients.

The diagnoses of illnesses were classified according to Nascher's classification of diseases in old age: Primary Senile Diseases; Secondary Senile Diseases; Preferential Diseases of Old Age; Modified Diseases of Old Age; and Diseases Uninfluenced by Old Age.[1]

The medical diagnosis of three patients was unknown. Two-thirds, twenty-two, of the total sample suffered with two or more serious problems. The largest number of patients suffered from arteriosclerosis which Nascher lists as a primary senile disease. The second largest number, seven, suffered from malnutrition which is listed by few authorities as a primary senile condition. Twenty-five of the patients studied suffered from diseases which are primary senile diseases.

Three of the patients were addicts--two drug addicts and one alcoholic. Two patients were admitted due to suicide attempts. One suffered from fractures of the hip, thigh, and wrist, and the other suffered from lacerations of the neck and wrists. Many authorities say that suicidal attempts are common in old age due to depressions and temper tantrums. The former was found to be true in these two cases.

The presentation of the characteristics of senile patients in this study group have shown some of the changes in health, marital status, financial status, and living arrangements that come to old people. Such changes involve methods of adjustment whether negative or positive. It is hoped that a discussion of characteristics peculiar to this group will give

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[1]Ignatz Nascher, Geriatrics, the Diseases of Old Age and Their Treatment (Philadelphia, 1916), pp. 65, 157, 206, 320, and 381.

further insight into their problems.

It has been found that psychosomatic unity is so infixed in the human body that when a disorder is present, both psychic and organic disorder are found. Recognizing the relative nature of physical and mental changes, the latter shall be discussed in the following chapter.

CHAPTER IV

ADJUSTMENT PROBLEMS PRESENTED BY PATIENTS

Psychological Aspects of Senility

Mental illnesses are more apt to occur as we grow older, one reason being that we will have lived long enough to have developed physiological, psychological, and social changes which are concomitant with the aging process. If we could make a chart of the frequency of mental illnesses starting with the first ten years and going up to the last ten, we would find that there is mental illness in more people in their last ten years than in their first, and that we have a steady increase with each ten-year period. This may not seem so at first, in view of the apparent great prevalence of mental disease, particularly of certain types, in the early years of life. However, if we think in terms of total population and the percentages of each group, we realize that there is always more population in the first ten years and that the number in each succeeding ten-year period falls off so that, while the actual number of mental illness in persons from sixty to seventy, seventy to eighty, or eighty to ninety, may be less than from thirty to forty, in proportion to the number of people in that particular age group there is more mental illness. Does this not indicate that mental illness in one sense is a disease of old age?

The mental disease of the aged person is generally referred to as senile psychosis and it is this clinical entity which for many years has been largely responsible for the increased admission rate of mental institutions. It is of special significance to note here that while between eighteen and nineteen per cent of all cases committed to mental hospitals in the United States are diagnosed as senile psychotic, only about two-thirds

of one per cent of the space in the ten leading textbooks of psychiatry is devoted to the entire subject of the cause, pathology, and treatment of all types of senile mental disease. No space at all is devoted to the prevention of mental diseases in the aged.[1]

Little is known concerning mental disease in the aged. However, when an old person is brought into the hospital with a mental disorder, if he is sixty years old or over, he is immediately classified as a senile psychotic. Senile psychosis, senile dementia, senile disorder, chronic brain syndrome, and senile brain disease are all wide generalizations. Of the thirty-two senile patients in this study group, ten received psychiatric diagnoses of senile dementia; four were diagnosed as having senile brain disease; four suffered from a chronic brain syndrome; four were diagnosed as senile psychotic, per se; two received diagnoses of "senility"; two were schizophrenics; one was a manic depressive; there were three addicts--two drug addicts and one alcoholic; one was suffering from an adult situational reaction; and the diagnosis of one patient was not recorded.

As was stated previously, these terms were used interchangeably and were all wide generalizations. There is only one thing about which we can generalize, and that is that in "all senile psychosis, there are three cardinal symptoms. Other symptoms only serve to further differentiate them."[2] The three symptoms as described by George Lawton are:

1. Disturbance of the memory. These are exaggerations of memory limitations which we find in the normal old person.

2. Disturbance in judgment. In senile psychosis, the emotions throw adjustments out of gear and fine points can not be decided.

3. The change in character itself. Originally we are of a specific type of personality. We are built according to the four types

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[1]George Lawton, New Goals for Old Age (New York, 1943), pp. 133-4.

[2]Ibid., p. 100.

> which describe people pretty well and which are to be recognized in the normal states of ordinary people. Each older person is already disposed toward a particular type of mental disorder, the same type he would have shown twenty years previously; the mental disorder is due to the whole personality, and when that breaks we bring into fruition all the difficulties of our lives. Hence, an equally important part of the phrase 'aged personality' is 'personality.'[1]

One's personality is patterned and built from the first ten years of childhood and when a person breaks down, he breaks down along one of the four lines of personality. The only new things in old age are the pressure of the three cardinal symptoms of senile disorder, which complicate the breakdown a little bit. It is somewhat unfortunate that the writer was unable to obtain a more detailed social history on the patients comprising the study group, in that a knowledge of the patients' earlier personality traits might have given more light in the area of the patients' ability and capacity for present adjustments.

While senile patients are generally considered the cases most easily and safely cared for outside of mental hospitals, as individuals they are often very difficult to manage and/or even socially dangerous in the home or community. These are the people who have the greatest difficulty adjusting to life situations and the changing social scene.

Personal and Social Adjustment

The concept of adjustment implies change in order to adapt successfully to a change in social situations. Adjustment may be personal or social. Personal adjustment signifies the reorientation of the attitudes and behavior of the person to meet the requirements of a changed situation. Social adjustment means adaptation to social change by modification of social norms and standards and sometimes also of the function, structure, and

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[1] Ibid.

operations of social institutions.[1] If the above is true, then adjustment or failure to adjust in old age must be considered in the context or in the inter-relations of changes in the aged person himself or changes in his situation. Adjustment for the old is difficult for many reasons but there are three main reasons for extreme difficulty. First, the aged no longer occupy the respected position characteristically held by the old in the great majority of past and contemporary societies.[2] Second, they are in the unsettled status of being useless and have no recognized function in our society. Third, they are not provided by our society with patterns which initiate or facilitate the transition from middle age to old age. This perhaps may be the most significant factor in the cycle of personal adjustment. Middle age is considered to be a relatively stable period of adjustment. However, with the transition into old age come certain evidences of it, such as decreases of energy, failing physical and mental powers, retirement, lower social status or at least a change in social status.

Many persons are unable to make plans for this transition into a new condition and are not able to anticipate the adjustment necessary for the change in situations and the contingent role. When this occurs the person becomes frustrated and from this may have difficulty with adjustment or may become completely unadjusted. The frustration which incurs often drives the person to more intensive attempts to adjust which if unsuccessful tends to cause and increase maladjustments.

The particular maladjustment on which our interest is focused is the mental breakdown. By this, the writer does not intend to exclude the importance of physical maladies which accompany mental disorders in the older

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[1]Ruth Cavan, op. cit., p. 10.

[2]Leo Simmons, The Role of the Aged in Primitive Society (New Haven, 1945), p. 26.

patient. However, in addition to the previous discussion of the medical aspects of senility, the writer feels that it is the psychological change, rather than the physiological, which makes adequate adjustment impossible for these senile patients.

Physical, Mental, Emotional, and Social Problems

Lawrence O'Kelly states that:

> In the early stages of senility there may be a gradual loss of the effects of social learning and inhibition. The person becomes careless of his dress and manner, forgetting social niceties. His emotional relationships with those around him change from love and affection to hate and hostility. He shows himself to be irritable at slight inconveniences, and concern for others turns into selfish and egotistically oriented attitudes. His attention to the environment lessens and is replaced by preoccupations about himself. With the lessened interest in events around him goes an impairment of recent memory, accompanied by a greater interest in the past and by forgetful, repetitive accounts of the same incidents. Emotional reactions become freer and less inhibited. His feelings are more easily hurt and many senile individuals develop paranoid preoccupations. As the condition progresses, the memory defects become more severe, the patient's vitality becomes less, and the incidence of delusions and hallucinations increases. Senility presents a genuine deterioration that may regress to the point where the patient has lost all contact with the environment and lives out his remaining life on a vegetative level.[1]

Though the above framework is lengthy, it was felt that no other source so adequately described the senile patient and the problems that he presents, problems which stem from his inability to adjust. The excerpt is most significant, however, in that the problems presented therein are of the same nature as problems presented by the study group.

Table 5 shows the adjustment problems as were presented by the patients in relation to the plan, subsequent history, and current status. The problems were classified under general headings which are explained as follows:

1. Unmanageable was inclusive of characteristics such as: loss of

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[1]Lawrence O'Kelly, Introduction to Psychopathology (New York, 1949), pp. 435-6.

memory, disorientation, confusion, hyperactiveness, refusal of food, insomnia, wandering from home, bizarre behavior, putting home in disorder and disarray, destruction of household items and other property, setting homes afire.

The brief sketch of a patient classified under unmanageable is E.M.

> This sixty-four-year-old female was admitted to --- Hospital with the accompanying citation: 'Patient is ramblic in speech, talks without sense or order, disoriented, suffers from numerous delusions, acts irrationally, threatened family.' The patient's family was interviewed briefly and the following information was obtained.
>
> The patient, mother of three children, first exhibited signs of mental disorder three and one-half months prior to admission. Up until this time the patient had lived with a daughter in Detroit. At the onset of her illness she was visiting another daughter in Texas. She visited there for two months and from there, traveled to Michigan to visit her son. It was at this time that the patient became extremely depressed (for no obvious reason), nervous, and refused to eat. The patient's son had her admitted to a hospital and she was given treatment for a 'bad case of nerves.' The patient remained in the hospital for approximately two weeks. At this time it was felt that she had recovered to the extent that she was able to fly to the daughter's home.
>
> For the first few days in the home the patient was as she had been previously. Then she became depressed again, refused to eat, and suffered a weight loss of ten pounds. A physician was consulted and he recommended that the patient be given six light meals per day. The patient would not eat herself and had to be fed by the daughter. Gradually the patient became more depressed, at times would be disoriented as to time, place and person, and began wandering out of the home when she had the opportunity.
>
> On the date of admission, the patient had wandered to a neighbor's home (7:00 A.M.) and after insisting that she be allowed to enter the house, requested that the neighbor come home with her because she, the patient, was going 'to hurt D--,' the daughter. The neighbor humored the patient and she seemed to have become considerably more calm. However, shortly after the neighbor's departure, the patient repeated her threat, adding that if she did not kill D-- she was going to 'put S--'s (grand-daughter) eyes out with the scissors.'
>
> After a while she became calm once more and all seemed well. However, shortly after S-- returned from nursery school, the daughter heard screams coming from the basement. Upon investigation, the patient's daughter found the patient chasing S-- with a knife.

2. Emotional outbursts was the categorical heading for patients who were subject to: temper tantrums, crying seizures, noisy, unruly, demanding, stubbornness, violence, talking excessively. This problem in adjustment of the senile patient is exemplified by the following sketch:

TABLE 5

ADJUSTMENT PROBLEMS PRESENTED BY SENILE PATIENTS IN RELATION TO PLANNING AND SUBSEQUENT ADJUSTMENT

Number	Unmanageable	Emotional Outbursts	Dangerous		Unfavorable Family Situations	Total	Previous Admissions	Previous Placements
			Suicidal	Homicidal				
1	X	...	X	...	...	2	...	1
2	...	...	...	...	X	1	...	...
3	...	...	...	X	X	2	...	...
4	X	X	...	X	X	4	3	2
5	X	...	...	...	X	2	1	1
6	X	X	...	X	...	3	...	...
7	X	...	...	...	X	2	...	...
8	...	...	X	...	...	1	...	...
9	...	...	X	X	X	3	1	1
10	X	...	...	...	X	2	...	...
11	...	...	X	...	X	2	2	...
12	X	...	...	...	X	2	...	...
13	X	...	...	...	X	2	...	...
14	X	X	X	X	...	4	...	...
15	X	...	...	X	X	3	...	...
16	X	X	...	...	X	3	...	...
17	X	...	...	...	X	2	4	4
18	X	X	...	X	...	3	2	2
19	...	...	...	...	X	1	...	...
20	X	...	...	...	...	1	...	...
21	X	X	X	X	X	5	...	...
22*	...	...	...	...	...	-	...	...
23	X	X	X	...	...	3	...	...
24	X	X	...	...	...	2	...	...
25	X	...	X	X	X	4	...	...
26	...	...	...	...	X	1	...	...
27	X	...	...	X	X	3	...	...
28*	...	...	...	...	...	-	...	1
29*	...	...	...	...	...	-	...	...

TABLE 5--Continued

Number	Unmanageable	Emotional Outbursts	Dangerous		Unfavorable Family Situations	Total	Previous Admissions	Previous Placements
			Suicical	Homicidal				
30	X	...	...	...	X	2	...	...
31	X	X	...	X	...	3	...	2
32	X	X	...	...	...	2	...	1
Total	22	10	8	11	19	70	6	9

*Family uncooperative.

Number	Discharge Disposition			Subsequent History		Current Status			
	Home	Convalescent Home	State Hospital	Readmission	Re-Placement	Home	Convalescent Home	State Hospital	Deceased
1	X	...	...	-	-	X	...	...	...
2	...	X	...	-	-	...	X	...	X
3	...	X	...	-	1	...	...	...	...
4	...	X	...	-	-	...	X	...	X
5	...	X	...	4	4	...	X	...	X
6	...	...	X	-	-	...	...	X	X
7	...	X	...	-	2	...	X	...	X
8	X	...	...	-	1	X	...	...	...
9	...	X	...	1	1	...	X	...	...
10	...	X	...	-	-	X	...	...	...
11	...	...	X	-	-	...	...	X	...
12	...	...	X	-	-	...	...	X	...
13	...	X	...	2	2	...	X	...	X
14	...	X	...	4	4	...	X	...	X
15	...	X	...	6	4	...	...	X	...
16	...	X	...	1	2	...	X	...	...
17	...	X	...	-	-	...	X	...	...
18	X	...	...	-	-	X	...	...	...
19	X	...	...	-	-	X	...	...	X
20	X	...	...	-	-	X	...	...	...
21	X	...	...	1	2	...	...	X	...

TABLE 5--Continued

Number	Discharge Disposition			Subsequent History		Current Status			
	Home	Convalescent Home	State Hospital	Readmission	Re-Placement	Home	Convalescent Home	State Hospital	Deceased
22	X	...	...	-	-	...	...	...	X
23	...	X	...	1	1	...	X	...	X
24	...	X	...	1	1	...	X	...	X
25	...	...	X	3	3	...	X	...	...
26	...	X	...	-	-	...	X	...	...
27	...	X	...	-	-	...	X	...	...
28	...	X	...	-	-	...	X	...	...
29	...	...	X	-	-	...	...	...	...
30	...	X	...	-	2	...	X	...	...
31	...	X	...	1	-	...	...	...	X
32	...	X	...	1	1	...	X	...	X
Total	7	20	5	12	15	6	17	5	13

M.C. is an eighty-one-year-old female, who was admitted to -- Hospital on 6-23-53. She was born in Michigan, residing in Detroit throughout her life. Her husband is deceased and she has one son. She has no financial income or other resources. The patient's son was interviewed briefly and the following information was obtained: The patient had not been admitted to the hospital prior to this admission but had been placed in three convalescent homes. She remained at the first one for three months, the second one for two years, and the third one for one year. The reason for the patient's discharges from these homes, as given by her son, was that she 'could not be handled.'

Prior to this hospitalization, she became 'violent,' frequently cried without obvious cause, and refused to eat (fear that son would poison her). She aggravated the one grandchild by pinching her and by pulling her hair. On the date of admission, the patient had set her clothes afire and it was at this time that her son sought hospitalization for her.

3. Dangerous was inclusive of both the patients found to be injurious to themselves and to others. Within this group fell the patients who attempted suicide, threatened suicide, attempted homicide and threatened homicide. Illustrative of patients who were classified as dangerous is Mrs. E.:

This sixty-nine-year-old female was born in Poland and has lived in Detroit for six years. Her husband is deceased and she has one deceased daughter. The patient had no financial income or other resources and had lived with her son prior to admission.

Previously, the patient had been in a convalescent home but was removed by the son, who stated that the cost of care was too expensive. The family then filed for the patient's commitment and it was during the waiting period for state mental hospitalization that the family found that they could no longer care for the patient in the home.

As stated by the son, the reasons for the patient's emergency hospitalization were as follows: the patient had frequent crying spells following which she would sit and stare into space for hours at a time. She stated several times that she was going to 'destroy herself' and several times injured herself in such attempts. She accused family members of stealing personal property from her and at times would threaten their lives. She was subject to temper tantrums and mood swings. She would not sleep or eat and threw objects at the daughter-in-law. In addition, the patient wandered around the house and in the streets.

The patient's son stated that he 'hated for someone else to have the burden of caring for her but that it was too difficult for the family to keep her in the home.' The family had cared for her for 'years' and it was felt that the patient had been the 'direct cause of her daughter's death.'

4. Unfavorable family situations was the broad classification which referred to problems in family relationships. It specifically referred to

cases wherein the patient could not be kept in the home due to illnesses of other family members; old age of family members responsible for the patient; employment of other family members; no family; family residing in other cities and states; no interest on part of family members; disruption of family life; financial inadequacies; and shortage of space in the home. The brief sketch of the M.L. case was an example of patients' situations who were classified under this broad heading.

> M.L., a seventy-year-old female, was admitted on 3/27/53. She was single and prior to admission had lived with her sister. The patient had no financial resources and was therefore entirely dependent upon her sister. This admission followed two previous ones and three previous placements. The reason for emergency hospitalization was that the patient was 'unmanageable in the home' and was an 'extra burden to her sister' whose husband had cancer. No further account of the patient's behavior was recorded.

Of the thirty-two patients comprising the study group, approximately two-thirds, twenty-two, were found to be unmanageable in the home. First among the problems was the appearance of depressive attitudes or reactive depressions and the general failure of memory. These were among the universally recognized features of senility. The differences of character and reactions of the senile were also exemplified here. We saw irritability, hostility turned toward family members, disruption of family life by adherence to routine, ill-temper, and offensive behavior.

One-third, ten, of the patients had difficulty in the area of emotional outbursts. It has been said that the aged are usually selfish. Their attitudes and reactions in special situations are interpreted as such due to their display of emotions. Crying spells, temper tantrums, and stubbornness were certainly indicative of the above and also the fact that the senile becomes less inhibited and his emotions become freer.

Almost two-thirds, nineteen, of the sample had difficulty in adjustment due to their danger to self and others. One-fourth, eight, of the patients

were dangerous to self and one-third, eleven, were dangerous to others. It is felt that because many suffer from ill health, they become depressed and worried to the extent that suicide is selected as a way out. Six patients out of the eight suicidal patients had unfavorable family situations. It seems that the desire to be loved, to receive attention, to have a useful status in the family, and not have these needs met might cause depressions--depressions to the extent that life is no longer worth living to the senile patient. The homicidal tendency indicates the change from love and affection toward family members to hostility and hate. Seven of the eleven homicidal patients had unfavorable situations. It also seems that feelings of persecution have an active part in this homicidal tendency.

These expressions and unadjusted behavior traits are seen present in varying degrees and combinations in every aged person. However, as is true with the senile patient, if they are not neutralized by an understanding attitude on the part of relatives, they will act destructively and counteract sympathy and active interest in the welfare of the aged person.

Unfavorable family situations were responsible for approximately two-thirds, nineteen, of the adjustment problems of the senile patients studied. Though it is equal in cause to "Dangerous" for unadjustment and maladjustment in this sample, it seems that this is one of the main problems of mental hygiene in the senile person. Family relations were affected by the presence of the senile person in the home. He is unsettling and troublesome in the home. He brings unhappiness and tensions into the home which might ordinarily be peaceful and happy. They may even make a pleasant relative irritable, overwrought, and impatient by their demanding need for service, attention, and close supervision. The whole family life may become disrupted, meals may become poorly and hastily prepared; children may be hindered in their play, deprived of the love and attention which they, too,

need; a husband may become resentful of the excessive attention demanded by the senile person. Specifically, it may be said that the senile person in this group created intolerable disorder and strain in the home.

The total number of problems for the entire study group was seventy and it was found that three-fourths, twenty-four, had adjustment problems in two or more areas. Twelve patients had problems in two areas, eight had problems in three areas, three had problems in four areas, one patient had difficulties in all areas, and the remaining patients had problems in only one area. The latter group comprised one-fourth of the entire study group.

Six of the patients had been admitted to Receiving Hospital prior to the admissions during the six month's period studied. One of the six had one previous admission, two had two previous admissions, one had three and one had four previous admissions. Nine of the patients studied had experienced previous convalescent placements planned by Receiving Hospital and/or families. Five of this group had been placed once prior to the period studied, three had been placed two times, and one had been placed one time.

In view of this discussion and the additional facts that senility is merely an exaggeration of the patient's earlier personality traits and abnormalities and that senility is gradual in onset, how can we account for the patient's need for "emergency hospitalization?" This question is one of special interest but one to which the study gave no answer.

Plans for the Senile Patient

What plans are available to the senile patient? From which of the following means may he find one which will partly or entirely meet his personal requirements and/or be amenable to his incapacities and inabilities: living alone in a room; sharing a home with relatives; living in a foster home;

entering a convalescent home, nursing home, hospital for the chronically ill, state mental hospital?

We can weigh these now that we have found the necessities for altering the senile patient's mode of living. The plan most frequently proposed at Receiving Hospital is that of placement in a convalescent home, hospital for the chronically ill, or nursing home. These are the available resources to the senile patient. Out of the sample of thirty-two patients, the final discharge disposition of over half, twenty, of the cases was that the patient be placed in a convalescent home. Approximately one-fourth, seven, of the patients were discharged home alone or with relatives (five of the seven had no problems in the area of unfavorable family situations). One-sixth, five of the patients were committed to a state mental hospital.

The Subsequent Adjustment of the Senile Patient

Of the twenty patients placed in institutions, over half, twelve, were readmitted to the hospital. One of the twelve was not placed but was discharged home and returned to the hospital from there. Seven of this group were readmitted one time, one was readmitted two times, one was readmitted three times, two were readmitted four times, and one was readmitted six times. Each patient was replaced each time. Four patients were not readmitted but were replaced in convalescent homes. These were cases in which the family sought advice and recommendations from the hospital.

Currently, six patients are in their homes with relatives, a little over half, seventeen, are in convalescent homes and five have been committed to a state mental hospital. The whereabouts of four patients was unobtainable. Of the seven patients discharged to their homes, six of these currently remain there. One has been committed to a state mental hospital. It might be significant to note that only two patients in this group had un-

favorable family situations at admission. Three of the five patients committed to state hospitals are currently there. Of the twenty patients finally placed in convalescent homes, over half, seventeen, remain or remained there (thirteen are deceased). This may be indicative of successful planning at Receiving Hospital. Seven of this group had previous admissions and unsuccessful planning by others.

Evaluation of Plans

It was felt that both the planning and the patient's subsequent adjustment were relatively effective. The medical social caseworkers who directly handled all placements of senile patients from the psychiatric wards screened the referrals and determined the resource which was best suited to the patient. Determination was made on the basis of the medical and psychiatric diagnoses, the patient himself, and the social history. The relationships with the convalescent homes were good ones and permitted the patient to be admitted on a trial basis. The institutions were somewhat careful in accepting senile patients and in the selection of patients attempted to choose those which would form a fairly congenial group. In addition, they were encouraged to return and also the patients who had extreme difficulty in adjustment (less than twenty per cent have been returned). Three convalescent homes and two hospitals for the chronically ill were contacted and they were of the opinion that the plans for the senile patient at Receiving Hospital were effective and that this was due mainly to the screening technique employed by the medical service workers and the superintendent of the hospital.

Though certain characteristics were accentuated by old age which make adjustments and planning difficult, some of these might be lessened by an intelligent understanding of the senile patient. George Lawton recommends

the following considerations for social workers, physicians, staffs of old age homes, et cetera:

> 1. We must arrange to use the senile individual in an economic way, or at least in a fashion to assure him (or her) that he is still a part of world affairs. No one wants to be told that he is on a shelf and no longer a part of society.
> 2. Many facts indicate that a reasonable variety in mental occupations is a factor in retarding senility.
> 3. If we want to deal honestly and well with the senile individual, we should relieve him as far as possible from worry, mental strain, anxieties, and feelings of financial insecurity.
> 4. The younger and more able associates of the senile should make allowances for his occasional loss of acuity in dealing with situations that require fine discrimination and tact, situations which in his earlier days he was able to handle perfectly.
> 5. Tolerance and understanding should be exercised in connection with those aged people who by virtue of a temperament that may become exaggerated or distorted by complicating factors show a marked egoism, along with uneasiness, restlessness, and a tendency to harp on their difficulties.
> 6. Finally, in a mental hygeine program for older people, we must give the aged individual some understanding of his personality in terms of the psychology of old age.[1]

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[1]George Lawton, op. cit., pp. 102-104.

CHAPTER V

THE ACTIVITIES OF THE MEDICAL SOCIAL CASEWORKER

Receiving Hospital is an emergency hospital, as noted earlier in Chapter II. The patients admitted are suffering from acute illnesses of relatively short duration, whether they be of a medical, surgical, or psychiatric nature. In view of this, Receiving Hospital had little to offer in the way of facility and service to the senile patient, who, in most instances, was in need of permanent custodial care. Perhaps it is significant to report here that the findings of this study show that the average period of hospitalization for the senile patient was twelve days. Legal regulations required that a disposition be within fifteen days, and due to this the psychiatric and social service staffs operate under some degree of pressure.

Not only was the need for custodial care essential from the medical, psychological, and social maladjustment aspects, but it had been the experience of the medical social workers and other professional personnel that the families' objective in emergency hospitalization was with the view of placements for the patients in convalescent homes and/or commitments to state mental hospitals.

The above was found to be especially true in this study also. The objectives in emergency hospitalization of fourteen families of the patients was that the patient be placed in a convalescent home. In four cases, the families were seeking advice relative to convalescent placements, and in five cases, the patients' families requested commitment to a state mental hospital. In four instances, patients were completely unattached and institutional care was obviously the only special resource for these dependent senile patients. There were only three instances in which families had sought emergency hospitalization in view of emergency treatment and the

patients' relatively immediate return home. In making the study, interviews with two families were unsuccessful. They expressed that the "experiences of placing their aged parents were too painful to discuss and that they preferred not to relate these."

The main functions of the medical social caseworker evolved from the two main areas discussed in the preceding paragraphs. However, an attempt to present an over-all description of the caseworker's activities would necessitate accounts of social work participation from the time of the patient's admission to the hospital to the time of his discharge.

One area of participation for the social worker is in ward rounds with the psychiatrist, the physician, and the intern. If the ward rounds were made for the purpose of discharge recommendations, after seeing and/or interviewing the patient, the psychiatrist made a temporary recommendation such as: obtain other hospital records, see what plans the family has for the patient, release immediately, hold patient so that her behavior might be further observed, and so forth. It was the job of the caseworker assigned to the case to effect the above requests. The results of the conference, per se, were discussed between the psychiatrist and the social worker in relation to specific problems in planning for the patient.

The next step in planning the discharge disposition for the patient was to contact relatives and make appointments to obtain a social service history and to prepare and help them to explore the psychiatrist's recommendations. Many times because of illness or unwillingness of the patient to have relatives contacted, the caseworker used various resources to obtain names and addresses of the relatives. If the senile patient was not too disoriented, confused, or suffering from memory losses it was sometimes possible for the social worker to secure this information from him and work with him. Many times the senile patients were not capable of this.

When the history was obtained from the relatives the goal of the worker was to secure a brief, pertinent social history with particular note of the onset and description of the recent and present behavior. Such a history enabled the social worker to arrive at a tentative evaluation of the patients' adjustment problems. The patients' relationships within the family situation, both present and past, are as important as his social relationships. This material was partial content of the social history. After securing the necessary information, the social caseworker verbally presented the material to the psychiatrist and recorded it on the patients' medical chart.

The family contact was a step in the process of social treatment which involved explanation to the family and further understanding of the family situation. As it was seen in this respect, the social history became a first step in the relationship shared by the patient, the worker, and the family. This, closely related to the medical and psychiatric diagnosis, was one of the means for effective planning. The social history and relationship problems were emphasized here because the latter were presented during the time in which the history was obtained. Relationship problems were also significant in that they constitute one of the fundamental problems with which the social worker dealt.

The conflicts which arose most frequently in parent-child relationships concerned dependence and financial, physical, or moral responsibility. Many adult children were unwilling to support or care for their parents, either because of hostility toward their parents or because it actually interfered with their own family life. Refusal to give help for either reason frequently resulted in feelings of guilt. For example:

> Mrs. X, 65, who for years worked and maintained herself, became ill shortly following the death of her husband in Alabama. Her only daughter, residing in Detroit, felt that Mrs. X could not be left

> alone and brought her to live in Detroit. Mrs. X did not adjust too well to life in the daughters' home in the beginning. She became melancholic, depressed, and refused to eat. Gradually, her condition became more serious. She became confused, disoriented as to time, place, and person, incontinent, and would wander out if close supervision was not maintained. The daughter and her husband had the mother admitted to the hospital by city physicians' orders; they felt that the mother was both physically and mentally ill and that her presence in the home had a disturbing effect on their two children. They could not afford to contribute to her care but would provide small extra necessities. Upon a doctor's recommendation, Mrs. X was moved to a nursing home, where she was maintained by the Department of Public Welfare. Before the transfer was made the daughter began to telephone the caseworker daily to express concern about the mother's health, questioning some aspects of the type of care given. There was evidence that she felt some guilt at not caring for Mrs. X and said frequently 'After all, she is my mother' and 'I never thought that I would have to put my mother away like this.'

It was necessary to help the daughter toward some understanding of her attitude toward her mother. Some satisfaction was achieved by encouraging the daughter to express her feelings regarding placing the patient out of the home, helping her to evaluate the reality of the situation objectively, and by interpreting the medical and psychiatric diagnosis and the mother's needs in these areas relative to adjustment.

Serious marital difficulties seldom occur in old age when there has been a good adjustment in earlier married life. However, early marital problems may lead to an intolerable situation in old age. Many times the social worker must handle such difficulties.

> The Q family had maintained a relatively poor relationship throughout their married life. Differences in attitudes, social standards, desires, and ambitions had caused frequent disputes between Mr. and Mrs. Q. Formerly, Mrs. Q derived some satisfaction from giving her husband almost maternal care (she regarded him as an inferior person), and from maintaining the home. Mr. Q derived satisfaction from his wife's attentions. Now, Mrs. Q is in poor health and Mr. Q cannot accept the new role of assuming responsibility for her. More and more frequently, he is giving overt expression to his long standing hostility and is now, after approximately forty-five years of married life, facing separation.

When the social worker found that Mr. Q's negative attitudes toward Mrs. Q could not be resolved and that an adjustment between the two partners was

impossible she talked with Mr. Q in terms of convalescent care for Mrs. Q.

These cases were cited to illustrate the function of the caseworker relative to helping the patient's family to recognize their own feelings and helping them to work through any of the physical or emotional problems that are apparent and pertinent to the patients' illness. Thus, this alleviated some of the obstacles to placement and of the patient's adjustment.

From the social history, inclusive of family relationships and plan descriptions, the psychiatrist made a diagnostic and prognostic impression. The evaluation of these, in the light of the needs of the particular patient, influenced the recommendation. It was realized that the type of care most suited to the senile patient was dependent upon his individual desires, capabilities, and capacity for adjustment. If it is recommended that the patient be transferred to a convalescent home, nursing home, or outlying hospital, the carrying out of the decision called for casework planning. It involved finding a home suited to the patient's needs, preparing him for the transfer, and helping him to accept placement in the particular type of resource. It sometimes also necessitated a referral to the Department of Public Welfare who maintained those patients in need of Old Age Assistance.

At the time of the transfer the worker sent the family notification that the patient was being transferred. Cases wherein the patient was not being placed but was being discharged home, the worker also notified the relatives of the discharge date and time.

Many times, the casework activities involved in planning for the senile patient had to be repeated several times in relation to one particular patient. As was shown in Table 5, page 28, twelve of the twenty patients placed one or more times were readmitted to the hospital. Seven of these patients were readmitted one time, one patient was readmitted two times,

one was readmitted three times, two were readmitted four times, and one was readmitted six times. At the time of each admission, planning had to be started anew for the patient for whom the previous plan had been unsuccessful. Of the twelve patients readmitted, one or more times, six were replaced one time, five were replaced two times, one patient was replaced three times, and three were replaced four times. Three of the patients warranting replacements were not readmitted to the hospital but were transferred from the convalescent home to their respective homes. In these instances families had placed the patient and oftentimes the families contacted the caseworker for advice regarding such placements and for recommendations as to proper placements. Eleven of the twelve patients who were replaced by caseworkers were currently well-adjusted to the convalescent home. The present status of one patient was unknown.

Table 6 shows the total number of contacts the social worker had both with the patient and the family.

TABLE 6

NUMBER OF SOCIAL WORK CONTACTS WITH THE THIRTY-TWO PATIENTS STUDIED, RECEIVING HOSPITAL, JANUARY-JULY 1953

Recorded Contacts of the Social Worker With Patients and Families	Total
Total	121
Admission	32
Readmission	26
Placements and Discharge	32
Replacements	31

Placements and other plans for discharge totaled thirty-two in number. Readmission contacts totaled twenty-six in number and replacement contacts were thirty-one in number. The total number of contacts was 121. Thus,

one can see the amount of activity involved in planning for the senile patient.

Briefly, the activities of the medical social worker may be summarized as:

> 1. Assisting in the interpretation of the hospital facilities and program to the patient and his family.
> 2. Assisting the family with problems arising from the patients' admission to the hospital, amelioration of the family anxieties to need of having the patient institutionalized if need be.
> 3. Formulating plans, with the assistance of other community resources.
> 4. Establishing a relationship with the family which will encourage them to maintain a positive attitude throughout the period of care or ultimately helping them to receive the returning patient with a fuller understanding and acceptance.[1]

The major contribution of the medical social caseworker lies in the development of a program which attempts to deal with the many variations to be found in the problems and adjustment required by this group of patients.

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[1] "The Psychiatric Social Worker in the Mental Hospital" (Conclusions and Recommendations: Report of the Committee on Psychiatric Social Work, Group for the Advancement of Psychiatry, Minneapolis, Minnesota, June 28-30, 1947), p. 3.

CHAPTER VI

SUMMARY AND CONCLUSIONS

The problem of the care of the aged is not new--it is as old as time itself. However, only recently have these problems become the object of both public and of scientific and social research. This rapid growth of interest in the years of later maturity is due to the ever increasing population of the aged. Presently, there are thirteen million persons sixty-five years of age and over in the United States.

Concomitant with the increase of the aged population is the increase of mental and physiological disorders of later life. Statistical analyses have shown that almost one-third of the first admissions to the United States hospitals occurred in persons sixty years of age and over.

The City of Detroit Receiving Hospital found this evidenced by the heavy influx of senile patients to its psychiatric wards. Very closely related to the impetus of admission was the difficulty involved in the adjustment problems of the senile patient and in planning for his care.

The purposes of this study were to define and to analyse the medical, psychological, and social problems of the senile patients as related to adjustment and to evaluate the effectiveness of the plans made for him. The study group was comprised of thirty-two female senile patients, white and non-white, sixty years of age and over, who were admitted to the City of Detroit Receiving Hospital between January and July, 1953.

The prevalence of many social and physical characteristics of the patients studied were shown in this thesis. It was found that of the patients studied, the median age of the group was seventy-two and that the ages ranged from sixty to ninety-four. This is indicative of the fact that the life span of the human being is steadily increasing. Over half of the

white patients were foreign-born and the non-white patients comprised only one-eighth of the entire group. These findings support theories that culture patterns are peculiar to certain age groups and to specific groups and that the patients' adjustment may be influenced by both.

Distribution of the study group by age and marital status was made and it was found that twenty-three of the patients were widows and five were married living with spouse. The study of family constellation revealed that twelve patients had no children, twelve patients had only one child, and that the remaining patients had three or more children. Investigation into financial support showed that twelve patients received chief support from investments, annuities, and bank accounts, and that eleven were recipients of Old Age Assistance. Only five were supported by their children. The remaining patients were employed. Approximately one-third, twelve, of the patients had previously lived alone. Eight had lived with their children, six lived in their own homes, four had lived in institutions, and two had lived with other relatives. These findings seem to indicate: that the lack of family life or complete unattachment has a detrimental effect on adjustment and that the detachment and implied loneliness of these patients are apparent; that the unity and intensity of family life is changing; that the standards of living of the old persons are lowered; that there is a tendency on the child's part towards independent provision and the aged person's dependence upon public funds; also that the chances for integration of the aged person into the family circle often proves unsuccessful or is not attempted.

It has been established in other studies that certain physiological changes and degenerations occur with age. The facts that there is a high frequency of all types of illnesses over the age of sixty years and that most old people suffer from two or more diseases simultaneously are also

well-founded. These were especially found evidenced in the study of the physical illnesses in the study group. The diseases were classified according to Nascher's classification of senile diseases.[1] It was found that approximately two-thirds, twenty-two, of the entire sample suffered with two or more serious physical problems and that twenty-five patients suffered from diseases which are primary senile diseases.

The presentation of characteristics of the sample group showed some of the changes in health, marital status, financial status, and living arrangements that involve methods of adjustment, whether negative or positive. Cases of individual patients were used to illustrate these changes and to aid in further development of insight into the adjustment problems of the senile patient.

The psychological aspects of senility were discussed relative to the fact that mental illnesses are more apt to occur as we grow older in that we live long enough to have developed physiological, psychological, and social changes. Little is known concerning mental diseases in the aged yet when old people with mental disorders are admitted to hospitals they are immediately classified as senile psychotic or other wide generalizations. Of the thirty-two patients studied, ten received psychiatric diagnoses of senile dementia, four were diagnosed as senile brain disease, four were suffering from chronic brain syndromes, four were senile psychotic, per se, two were diagnosed as senile, three were addicts, and two were schizophrenic and manic. As is shown here, wide generalizations are used to describe mental disorders in the aged person. However, there are only three cardinal symptoms and these were discussed in the thesis.

The concept of adjustment, personal and social, was reviewed in the

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[1]Ignatz Nascher, op. cit., pp. 65, 157, 206, 320, and 381.

sense that adjustment or failure to adjust in old age must be considered in the context or in the inter-relations of changes in the aged person himself or in the changes in his situations. Briefly, the main reasons for extreme difficulty in adjustment of the aged person are change in position, change in status, and inadequate preparation for the transition from middle age to old age.

The adjustment problems presented by the patient in relation to the plans for him were shown and discussed. The specific problems were classified under general headings: unfavorable family conditions; unmanageable; emotional outbursts; and dangerous (suicidal and homicidal). Case sketches were used as illustrative materials. Two-thirds, twenty-two, of the sample were classified as unmanageable. Unfavorable family situations gave rise to problems of nineteen patients. Approximately one-third, ten, had difficulty in the area of emotional outbursts. Nineteen were dangerous, either to self or to others. It was found that twenty-four patients had adjustment problems in two or more areas and that the adjustment problems of the entire group totaled seventy in number.

Six patients had been previously admitted to the hospital one or more times and nine had experienced previous convalescent placements. As is apparent, the adjustment problems of senile patients are multifarious and present many obstacles in planning for his care.

In view of the fact that specific problems under unfavorable family conditions were many, an inventory of family objectives in admission and attitudes towards plans was made. This revealed that in twenty-three cases the families' objective in emergency hospitalization was placement in a convalescent home and/or commitment to a mental hospital. Seventeen families felt that the care of the senile patient was a city or state responsibility,

eight felt that it was a family responsibility, and in nine cases the patient was unattached or families were uncooperative. Many feelings of guilt, hostility, and ambivalence were expressed concerning the question of responsibility. However, this further supports the idea that there are trends toward diminishing family unity, independent provision, and dependence upon public funds and agencies. It is also an indication that family life is disrupted by the presence of the senile patient in the home, that they create intolerable disorder and strain, and that satisfying the needs of the patient may be at too great a cost to the young people in the situation. Recommendations for persons who have the responsibility of aged patients were made.

Convalescent homes, nursing homes, outlying hospitals and state hospitals are the resources for the senile patient. The plan is determined by an evaluation of the one which will partly or entirely meet the patient's requirements and/or be amenable to his inabilities and incapabilities. Of the sample, over one-half, twenty, were placed in convalescent homes, seven were discharged home, and five were committed to a hospital for the mentally ill. From this, it seems that institutional care for the senile patient is the most acceptable plan and that psychotherapy for this patient is nil.

However, twelve of the twenty patients placed were readmitted to the hospital, from one to six times. This indicates the patient's unadjustment and justifies selectivity of patients admitted to convalescent homes.

Of the twenty patients receiving replacements, seventeen are currently in convalescent homes. In view of this, the planning for these patients was effective in that careful evaluation of social, medical, and psychological needs was extensive in that the patient made an adjustment adequate enough to remain within the setting to which he was referred. Convalescent home personnel have voiced no adverse feelings to the plans made by

Receiving Hospital.

The participation of the medical social caseworker is extensive in understanding and planning with and for the senile patient. One of the areas is in ward rounds, at which time there is close case coordination between the psychiatrist, the physician, and the social worker. This is in terms of conferences in relation to specific problems in planning for the patient. Thus, the social worker had at least thirty-two conferences concerning the thirty-two patients studied with the psychiatrist. The thirty-two patients studied presented a total of seventy problems around discharge planning.

A next step in planning was to obtain a social history from the family and to prepare and help them to explore the doctor's recommendation. Particular note was given to the patients' relationships within the family. It was around this area that the worker most often gave clarification, psychological support and insight. Therefore, great emphasis is placed upon the establishment of positive worker-family relationships. Cases were used to exemplify this range of treatment and the social worker made at least thirty-two family contacts with one or more members of the family.

From the social history, inclusive of family relationships and plan descriptions, the psychiatrist made a diagnosis and prognosis. Then the recommendation was made which was best suited to the senile patient. This was done with each of the thirty-two patients studied.

The carrying out of the decision is a casework plan which included finding the best resource, preparing patient for transfer and acceptance of placement, and the family's notification of patient's transfer.

Casework activities oftentimes were repeated in planning for the senile patient. Twelve of the twenty patients placed were readmitted one or more times which meant that family contacts and replanning were necessary in each

case at readmission. Twenty-two plans were made for the twelve patients. In all, 121 contacts and plans were made for the thirty-two patients studied. Thus, one can see the amount of activities involved in planning for the senile patient.

Changes associated with senility to the problems of adjustment in this life span have been discussed. The problems of adjustment in old age and the planning for the aged do not end here but are a continuing process in community education. The job ahead is a tremendous one, but we, as professional workers specializing in the health, welfare, and adjustment of all people, must meet the challenge of our ever increasing aged population and plan for our present and future senior populus.

APPENDIX

SCHEDULE

Name _____

Case No. _____ Date of Admission _____

Status _____ Age _____ Race _____ Religion _____

Place of Birth _____ In Detroit _____ Legal Residence _____

Relatives	Addresses	Phone No.
Husband		
Children		
Others		

Financial Record

Own Home _____ Rent Amount _____ Bank Account _____

Insurance; Sick, Accident, etc. _____

Old Age Assistance _____ Other _____

Employed _____ Occupation _____ Amount _____

Reason for Emergency Hospitalization _____

Adm. Diagnosis	Concomitant Phy. Illness

Final Diagnosis _____

Final Disposition _____ Date _____

Family's Objective in Emergency Hospitalization _____

_____

_____

Family's Reasons for Seeking Custodial Care _____

_____

_____

Family's Attitude Toward Plan _____

_____

_____

_____

Person or Agency Responsible for Financial Costs _____

Subsequent History _____

_____

_____

_____

_____

Current Status _____

_____

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